Letters to the Editor

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An Investigation of Increased Tuberculosis Case Reports in Santa Clara County, California, 1993–1994

Between 1993 and 1994, Santa Clara County (California) tuberculosis case reports increased 25% (227 vs 283 reports; 14.5 vs 17.8 cases/100 000 population). The tuberculosis case count and rate for California declined by 6% and 8%, respectively, during this period. Santa Clara was one of only two California counties that reported at least 100 tuberculosis cases in 1993 and increased reports in 1994. We report on the contribution of surveillance artifact to this increase.

We analyzed incident-verified tuberculosis disease cases reported to Santa Clara County.[1,2] We compared annual cases by report date and type of confirmation (laboratory vs clinical) and interviewed county tuberculosis program staff about reporting practices and surveillance activities implemented in 1994.

The percentages of laboratory-confirmed tuberculosis cases reported to the county were 78% between 1985 and 1990, 89% between 1991 and 1993, and 77% in 1994. For comparison, between 1985 and 1994, 75% of California tuberculosis cases were laboratory confirmed. If the statewide distribution of laboratory and clinically confirmed tuberculosis cases approximates the true distribution, clinically confirmed cases may have been underdetected by the county between 1991 and 1993.

Between 1993 and 1994, laboratory-confirmed tuberculosis cases increased by 6% and clinically confirmed cases increased by 195%. In late 1993, two disease control investigators trained in active disease strategies for communicable diseases were hired by the county. These individuals implemented more aggressive (1) follow-up and medical supervision of suspected tuberculosis cases reported from the county hospital, (2) outreach to immigrants entering the county with class B medical notifications for tuberculosis, (3) outreach to private physicians and private laboratories, and (4) follow-up of negative acid-fast bacilli smear and tuberculosis culture reports from the county public laboratory.

Our findings suggest that the increase in tuberculosis cases in 1994 resulted largely from increased detection of clinically confirmed cases by the county rather than from an increased incidence of the disease. Clinically confirmed cases require a high index of suspicion among diagnosing physicians, rigorous compliance by physicians in reporting, and greater health department resources to reclassify cases from suspected to verified tuberculosis. Further study is required to determine the extent to which increased detection of tuberculosis cases resulted from increased access to care, increased diagnoses by physicians, improved reporting of diagnosed cases by physicians, and increased verification of suspected cases by the county.

This study suggests that targeted supplemental surveillance activities are effective in increasing tuberculosis case detection. Early and complete detection of tuberculosis cases by the county is essential to ensure appropriate treatment of tuberculosis patients and prompt evaluation and treatment of persons in contact with patients. In addition, complete case counts accurately reflect the tuberculosis burden in the community and are essential to plan and evaluate tuberculosis control programs. □

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References

1. Centers for Disease Control. Case definitions for public health surveillance. *MMWR Morb Mortal Wkly Rep.* 1990;39(RR-13):39–40.
2. McCombs SB, Onorato IM, McCray E, Castro KG. Tuberculosis surveillance in the United States: case definitions used by state health departments. *Am J Public Health.* 1996;86:728–731.

On 'Accidents'

Regarding the historical review on accidents,[1] it probably is no coincidence